



MIChild and Healthy Kids Application

If you need help with reading or writing to complete this application, call toll-free **1-888/988-6300** → **TTY-1-888/263-5897**

Language interpreter services will be provided free of charge. Languages other than Spanish and Arabic are available.

Si Ud. necesita ayuda con la aplicacion, llamanos. La llamada es gratis **1-888/988-6300**

إذا كنت تحتاج إلى مساعدة لتعبئة هذا الطلب، يرجى الإتصال على الرقم السمائي (١٨٨٨٩٨٨٦٣٠٠) وشكراً.

Hours: Monday through Wednesday 8 AM to 8 PM → Thursday & Friday 8 AM to 6 PM → Saturday 9 AM to 1 PM

MIChild is a low-cost health coverage program for children under the age of 19.

Healthy Kids is a free health coverage program for children under 19 and pregnant women of any age.

Please fill out this entire application. If a question does not apply to you, write N/A in that space. **You must write the Social Security Number (SSN) for every child and pregnant woman you are applying for.**

Note: If you are pregnant and under 18, you have the option of applying for yourself without reporting your parent's information or you can apply as part of your family. Pregnant women do not need to choose health and dental plans.

CHOICE OF HEALTH AND DENTAL PLANS

To find out which health plans are in your area, call toll-free **1-888/988-6300**. You can also call your doctor or dentist to see if they are part of a MIChild Plan. **The application is not complete until both a health and dental plan are chosen.**

Health Plan: _____

Dental Plan: _____

INFORMATION ON ADULTS IN HOUSEHOLD

Adult
#1

Adult
#2

Name	First Name		
	Middle Name		
	Last Name		
Full Michigan Address	Street Address		
	City		
	County _____		
	Zip Code		
Mailing Address (if different than above address)			
Telephone number where this person can be reached (including Area Code)		day: ____ / ____ / ____ evening: ____ / ____ / ____	day: ____ / ____ / ____ evening: ____ / ____ / ____
Sex (circle one)		Male Female	Male Female
Date of birth (month, day, year)			
Social Security # (optional)			
Have you received cash assistance (FIP) in the last four months?		Yes No	Yes No
Are you an American Indian or Alaska Native?		Yes No	Yes No
Are you Hispanic or Latino?		Yes No	Yes No
Racial heritage (optional) (see codes at bottom of page)			
What is your primary language?			

Use these letters to show racial heritage. *You do not have to fill in racial heritage*

I-American Indian or Alaskan Native A-Asian or Pacific Islander B-Black or African American J-Native Hawaiian E-Other Race O-White
Z-Mutually Defined or Multiracial

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Official use only

M _____

CHILDREN AND/OR PREGNANT WOMAN INFORMATION

Child
#1

Child
#2

Child
#3

Pregnant
Woman

(Please attach additional pages, if needed.)				
Applicant's Full Name	First Name			
	Middle Name			
	Last Name			
Is this person's address the same as the adult's? (The child and/or pregnant woman must apply from their home address.)	Yes No	Yes No	Yes No	Yes No
Are you applying for this person?	Yes No	Yes No	Yes No	Yes No
Sex (circle one)	Male Female	Male Female	Male Female	N/A
Is this person pregnant?	Yes No Due date	Yes No Due date	Yes No Due date	Yes No Due date
Is this person an American Indian or Alaska Native?	Yes No	Yes No	Yes No	Yes No
Racial heritage (optional) (see codes at bottom of page 1)				
What is this person's primary language?				
Date of Birth (month, day, year)				
This person's Social Security Number (required) (see note at bottom of page)				
Citizen of the United States? (If No, send copy of the document that provides the person's legal status)	Yes No	Yes No	Yes No	Yes No
Relationship to adults from page 1 (son, daughter, adopted, step, spouse, none, self, etc.)	Adult 1 _____ Adult 2 _____	Adult 1 _____ Adult 2 _____	Adult 1 _____ Adult 2 _____	Adult 1 _____ Adult 2 _____
Child support received for this child (per month)	\$ _____	\$ _____	\$ _____	\$ _____
Were the child's parents ever married to each other?	Yes No	Yes No	Yes No	Yes No
Are both parents of the child living in the home?	Yes No	Yes No	Yes No	Yes No
Are you a court appointed guardian for this person?	Yes No	Yes No	Yes No	Yes No
Is this person the parent of a child?	Yes No	Yes No	Yes No	Yes No
Does this person have health insurance? (If Yes, send copy of front and back of card)	Yes No	Yes No	Yes No	Yes No
Has this person had health insurance (from an adult's job) that ended in the past 6 months? (If Yes, attach written statement explaining why the insurance ended)	Yes No Date Insurance Ended _____	Yes No Date Insurance Ended _____	Yes No Date Insurance Ended _____	Yes No Date Insurance Ended _____
Does this person have any unpaid medical bills from the past 3 months?	Yes No	Yes No	Yes No	Yes No
Does this person have Children's Special Health Care Services? (Crippled Children program)	Yes No	Yes No	Yes No	Yes No
Has this person received cash assistance (FIP) in the past four months?	Yes No	Yes No	Yes No	Yes No
Is this person a migrant worker?	Yes No	Yes No	Yes No	Yes No
Does this person intend to remain in Michigan?	Yes No	Yes No	Yes No	Yes No
Has paternity been established for this child?	Yes No	Yes No	Yes No	Yes No
If a parent is not in the home, please provide the absent parent's name and address. (Please attach additional pages if needed.)				

NOTE: Processing time for your application will be reduced if you send **copies** of the following with your application:

- If any applicant is not a U.S. citizen, send a copy of the document that provides the person's legal status in the U.S.
- Insurance: send a copy of the front and back of each insurance card
- **If pregnant with more than one child, please provide Doctor's statement**
- If applicant's social security number has not been obtained, please supply proof that the number has been applied for. The local office will help the applicant apply for a social security number if requested.

INCOME INFORMATION

WAGES

(Please attach additional pages, if needed.)

	Are you employed?	Monthly Gross Pay (before taxes)	Monthly Take Home Pay (after taxes)
Adult 1	Yes No (circle one)	\$ _____ /month (tips included)	\$ _____ /month (tips included)
Adult 2	Yes No (circle one)	\$ _____ /month (tips included)	\$ _____ /month (tips included)

SELF EMPLOYMENT

Name of self-employed person	Gross <u>monthly</u> income, minus allowable* federal tax deductions (*DEPRECIATION not allowed)
	\$ _____ /month
	\$ _____ /month

OTHER INCOME

List all other income received by household members.

1.Unemployment Benefits
2.RSDI (Soc. Sec. Benefits)
3.Worker's Compensation

4.Military Allotment
5.Veteran's Benefits
6.Retirement Benefits

7.Interest Income
8.Rental Income
9.Strike Benefits

10.SSI (Supplemental Security Income)
11.Investment Income
12.Cash from Friends,Family

13.Other: Please specify _____

List below the household members who receive the Income	Type of Income (from above list)	If RSDI Income please enter Claim #	Monthly Gross Income (before taxes)
			\$ _____ /month
			\$ _____ /month
			\$ _____ /month
			\$ _____ /month
			\$ _____ /month

NOTE: If you do not have any income, please briefly explain below how you support yourself and your family:

INCOME DEDUCTIONS

Child Support You Pay For Children Not Living With You:		Do You Pay Child Day Care So You Can Work? *		Expenses For Rental Property You Own:
Adult 1	\$ _____ /month	Adult 1	Adult 2	\$ _____ /month Do not complete this box unless you reported rental income. (These are your monthly expenses for the rental of property that you own and rent to others.) Name of rental property owner: _____
		For Child 1	Yes No	
		For Child 2	Yes No	
		For Child 3	Yes No	
Adult 2	\$ _____ /month			

* Child-care expenses cannot be claimed if you pay your spouse (or other parent of child) to watch the child. Also, the child must be under the age of 15 (or under 18 and need care due to a mental or physical limitation).

I agree to the release of information from this application and supporting proof in order to evaluate and verify eligibility. I agree that the Department of Community Health (DCH) or Family Independence Agency (FIA) may use necessary medical information about me or my children, including any information about HIV, ARC, or AIDS to determine eligibility for a specific program or for other administrative purposes. I understand that these agencies will maintain confidentiality according to the Health Insurance Portability and Accountability Act, 42 CFR 431.300-431.307, and any other applicable federal and state laws and regulations. This authorization is valid for 3 years from the date this application is signed.

I understand that when the DCH pays the cost of medical services, any right to recover costs from a third person or public or private contractor, except Medicare, is transferred to the department. Payment of any recovery under such right is to be made directly to the State of Michigan, DCH or its agent.

I understand that if I get more benefits than I am entitled to through my fault, I may have to repay any extra benefits received.

I understand that this application is for one type of health benefit and is not a full Medicaid application. I understand that if found not eligible for health benefits under MICHild or Healthy Kids, I may be eligible for Medicaid benefits on some other basis. I understand I have the right to complete the FIA-1171 to apply for cash benefits, Food Assistance, Day Care assistance or other services at the local FIA office.

Neither the DCH nor FIA will discriminate against any individual or group because of race, sex, religion, age, national origins, marital status, disability or political beliefs. I understand that if I wish to file a discrimination complaint I can contact the Dept. of Civil Rights service center by calling 1-313/456-3700 → TTY-1-877/878-8464.

I understand that children enrolled in MICHild or Healthy Kids will be eligible for 12 months unless they turn age 19, move out of state, fail to pay MICHild premiums or are deceased.

I understand that computer cross-checking may be used to verify information I have provided on this application.

If you would like help with paternity and/or the pursuit of financial or medical support contact your local FIA office.

I understand that my children can still receive Medicaid benefits if I do not cooperate with the Office of Child Support for the establishment of child paternity and/or the pursuit of financial or medical support.

If you need help with reading or writing to complete this application, under the Americans with Disabilities Act, you are invited to make your needs known by calling **1-888/988-6300 [1-888/263-5897 for persons with hearing and speech disabilities]** or your local FIA office. Language interpreter services are available at no cost.

You have the right to appeal a decision made by the DCH or FIA. You will be notified of your rights if your application is denied for any reason.

PLEASE SIGN AND DATE YOUR APPLICATION

I certify under penalty of perjury that the information on this application is true, complete, and accurate to the best of my knowledge. I understand that any misrepresentation of the facts means that benefits may be taken away. I authorize the state to verify the information on this application.

Signature

Date

Authority: Titles XIX and XXI of the Social Security Act. Completion of this form is required to enroll in a health plan.

MAXIMUS is the Administrative Services Contractor for MICHild, under contract with the DCH.

When your application is filled out, send it to:

MICHild
PO Box 30412
Lansing, MI 48909



Jennifer Granholm, Governor
Janet Olszewski, Director